

**A FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND**  
**SECTION 2. CORE SERVICE ELEMENTS**

**INDIVIDUAL PLANNING OF SERVICES**

Service Element	Description of Needs	Ways in Which Services May Respond
<b>Individual Assessment of Needs</b>	Assessment and regular review of health (mental and physical), social care and housing needs of each individual taken on by the service. People who receive services and their families must be fully involved in the process.	<ul style="list-style-type: none"> <li>• Joint individual care planning mechanisms between health, social work and primary care based on the needs expressed by the individual using the service and on the Care Management and Care Programme Approach process.</li> <li>• Self assessment approaches and availability of independent advocacy will facilitate this.</li> <li>• Access to staff with specialist knowledge of black and ethnic minority issues to ensure that cultural factors are taken fully into account in assessment and care planning.</li> </ul>
<b>Assessment</b>	<p>A full and accurate assessment at the time of first contact with the service. This will involve:</p> <ul style="list-style-type: none"> <li>• a history or account of the development of the difficulties from the person and possibly a relatives or caring person;</li> <li>• an account of the person’s previous way of life, including past episodes of mental health problems, physical illness, and treatments;</li> <li>• a listing of the person’s problem areas, strengths, or life difficulties.</li> </ul>	<ul style="list-style-type: none"> <li>• Any qualified multi-disciplinary community mental health team member should be able to make an assessment on behalf of the team;</li> <li>• If a problem presented by the person requires the particular expertise of another member of the CMHT, it should be easy to gain this within a short time;</li> <li>• The problem list should be separated into “psychological”, “social” and “physical” sections and should be checked out with the person presenting;</li> <li>• Actions to deal with each problem are specified, a measure of success defined and the person responsible for the action identified.</li> </ul>
<b>Care Planning</b>	<p>There should be joint agency protocols on Care Management, the Care Programme Approach, Community Care Orders and on admission and discharge processes.</p> <p>Care planning needs to demonstrate the involvement of the people who receive services and those who care for them in the development and review of plans. Individual plans should:</p> <ul style="list-style-type: none"> <li>• be explicit about the problem(s) to be addressed, the proposed interventions (and agencies) and predicted outcomes;</li> <li>• be multi-disciplinary and multi-agency in design and delivery; and with one identified key worker responsible for: <ul style="list-style-type: none"> <li>- co-ordinating the delivery of contracted services;</li> <li>- liaising with the patient’s primary care service;</li> <li>- ensuring that all agencies are working towards the objectives of the care plan; and</li> <li>- reviewing the plan regularly.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Joint care planning procedures which operationalise guidance and involve the primary health care team and independent sector.</li> <li>• Clear processes for demonstrating understanding/agreement eg documentation signed by the person using the service.</li> <li>• Joint training to familiarise staff with joint working and to equip them with the key competencies. This process should be jointly monitored by management.</li> <li>• The development of good joint working practice between health and social work staff.</li> <li>• Joint training for new recruits and for existing staff of every component of the service.</li> </ul>